

# Medicaid Managed Care Basics

Presentation to the Specialized  
Services Subcommittee  
September 13, 2010



Muskie School of Public Service

# Overview of Presentation

- What is Medicaid Managed Care? Specifically, what is risk-based contracting?
- How does it compare to existing MaineCare approaches?
- What changes for a MaineCare member?
- What do the federal Centers for Medicare and Medicaid Services (CMS) require states to do?
  - Choice, Quality, Services, Payments

# What is Medicaid Managed Care?

- Medicaid managed care is a general term that describes a number of different approaches that states use to improve quality and control spending.
- Maine is specifically working on a form of managed care called **full risk contracting**.
- This means the contractor (**not** the member) can lose money (is “at risk”) if care is not provided in a cost-effective way.

# How does it work?

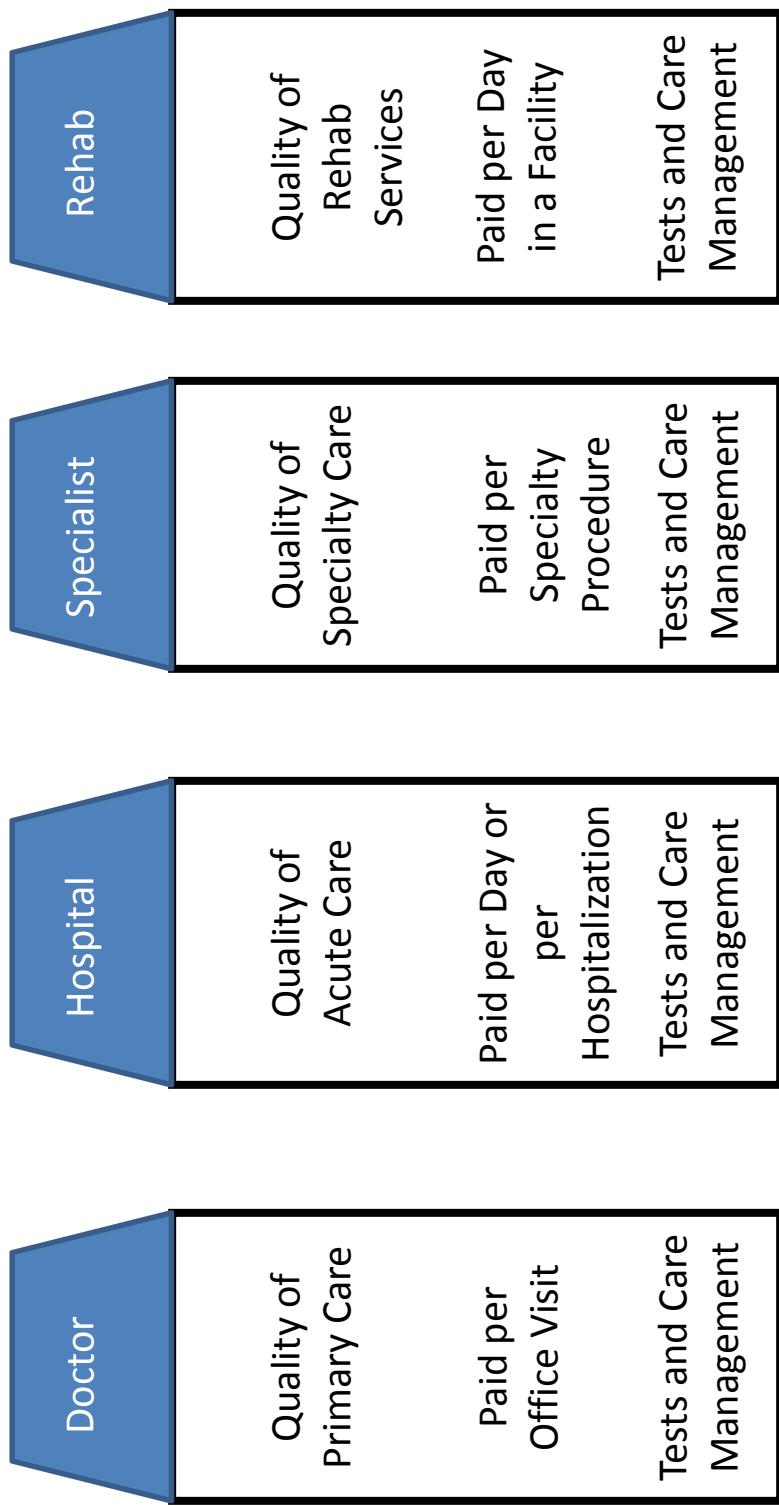
- MaineCare will set quality standards. For example, it may require that children have regular doctor visits.
- A contractor agrees to provide all needed MaineCare services and meet quality standards for a set price, called a **capitation**.
- Its called a capitation because the fee is paid per capita, or per person enrolled in the plan.
- Sometimes, people refer to this as a “**PPM**,” which means “Per Member Per Month.”

Primary Care Case Management (PCCM)	Administrative Services Organization (ASO)	Full Risk Contracting
<b>With whom is the State contracting?</b>	Primary care providers (usually a doctors)	A third-party vendor. (Maine currently contracts with APS)
		An entity that can legally assume full financial risk (usually an MCO)
		Coordinate care, make referrals, be available
		Utilization review, enrollment, claims processing, reports
		Fee for admin function provided; services are FFS
		Full capitation for coordination and all services
		State may provide quality incentives to ASO, through ASO to providers, or directly to providers
		State provides quality incentives to primary care providers
		State provides quality incentives to contractors, who in turn work with providers

# How does this compare to what MaineCare is already doing?

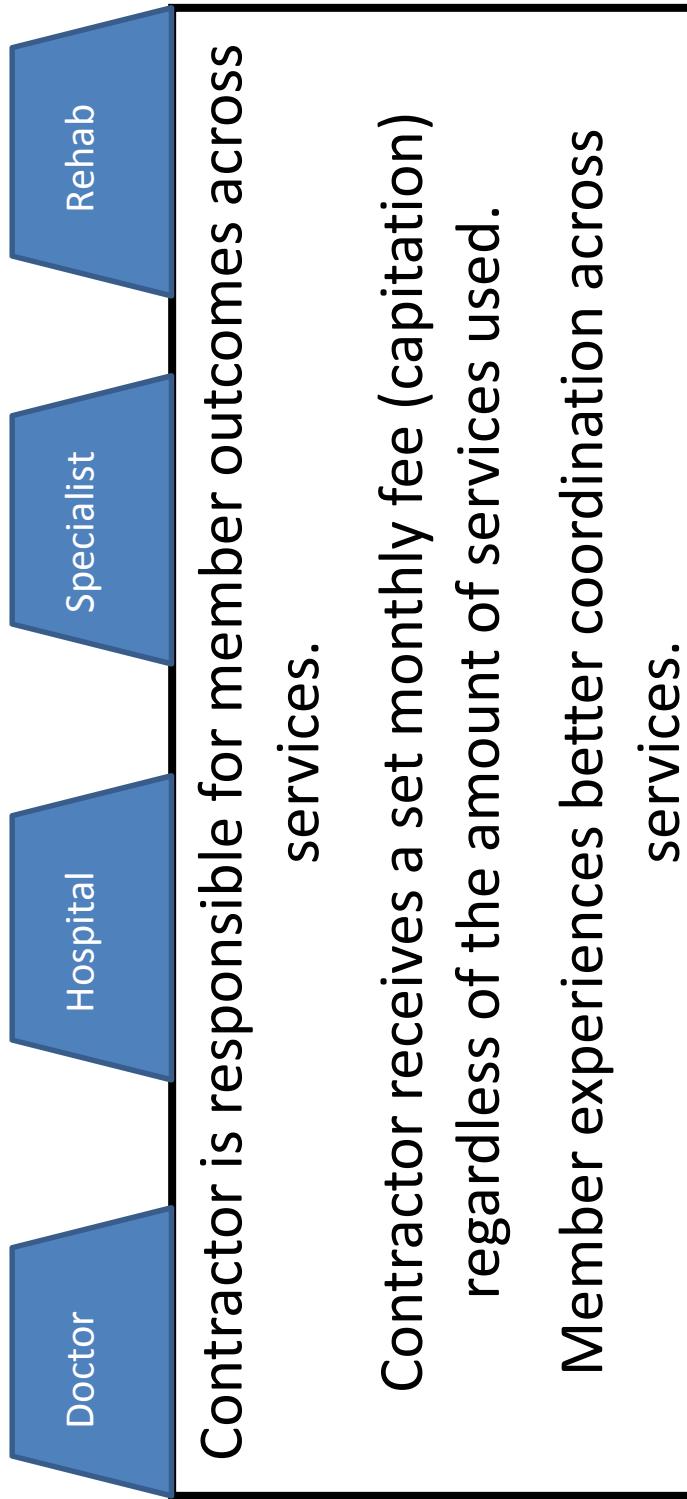
- MaineCare already has a large Primary Care Case Management (PCCM) program, but no risk-based program.
- Maine currently contracts with APS, an Administrative Services Organization (ASO), to manage many mental health services.
- MaineCare had a small risk-based program in the late 1990s that was discontinued.

# Current System: Accountability and Payment in Service Silos



Member, family and individual case managers cope with multiple, separate services.

# Future System: Global Accountability and Payment



# What changes for members?

- Change: member must choose a plan.
- MaineCare wants to offer at least two plans, through two contractors.
- No change: member chooses a doctor. This happens now in Primary Care Case Management.
- No change: member must get a referral from the doctor for many specialty services.

# Choice

- With proper federal permission, members may be required to get their services through a designated contractor. This is called **“mandatory enrollment.”**
- However, with some exceptions, members must have a choice of plan (more than one contractor to choose from) and a choice of doctor within the plan.

# Quality

- CMS requires State Medicaid programs to have a Quality Management Program in place.
- A State must also contract separately for an **External Quality Review Organization (EQRO)** to help the State monitor the contractors.
- A State must also ensure that members are able to complain about their services, and to pursue grievances and appeals.

# Services

- Managed care may NOT be used to offer fewer services— a State must offer all of the services available in its traditional program. (They don't all need to be offered through the contractor, however. A state may continue offering some through its traditional program.)
- Under CMS rules, a contractor may offer extra, "**“in lieu of” services**, not normally covered by MaineCare, but it must be cost effective.

# Payments

- Capitation payments must be actuarially sound. That means they must be adequate to provide the covered services.
- Actuaries calculate the capitation amount by looking at how much the state spent in a previous year, and making adjustments.
- CMS requires that payments be no greater than what the state would have spent if members had stayed in the traditional system.

# Discussion

- Questions?
- Priorities for more information?